APPENDIX 12a

Department of Health & Social Service
Division of Health
DOH 4024 (Rev 3/86)

State of Wisconsin

WIC MEDICAL REFERRAL FORM
FOR

☐ Infant (to 1 yr.) ☐ Child (1-5 yrs)

PATIENT'S NAME _____ PARENT/CARETAKER'S NAME _____

ADDRESS _____

PHONE _____ BIRTHDATE _____ AGE _____ SEX: _____MALE _____FEMALE

The following information is required for referral to the WIC Program:

Present wt: _____	Hct: _____ % and/or	Infants Only:
Present lgth/ht: _____	Hgb: _____ gm	Birthweight: _____ lbs. _____ oz.
Date taken: _____	Date taken: _____	Birthlength: _____ in. _____ 8ths.
		Gestational age: _____ wks.

Vitamin/Mineral Rx: _____ Formula/Milk Rx: _____

Please check (✓) any medical/nutritional condition which might (or has) influenced the health of this child.

- ☐ Lead poisoning
- ☐ Birth injury (i.e. cleft lip/palate)
- ☐ Frequent infections
  - _____ number of colds in last 6 months
  - _____ number of otitis media in last 6 months
  - _____ number of throat infections in last 6 months
- ☐ Diabetes, CP, CF
- ☐ Severe dental problems
- ☐ Clinical signs of nutrient deficiency:
  _____

Additional Diagnoses/Health Concerns: _____

_____

_____

Physician or Health Professional's Name _____

Address: _____

_____ Phone: _____

Medical Office/Clinic: _____

Signature: _____ Date: _____

Final eligibility is based on a combination of nutritional, financial and medical criteria which will be determined by the local WIC Project.

This is an Equal Opportunity Program. If you believe you have been discriminated against because of age, race, color, handicap, sex, creed, national origin, ancestry, sexual orientation, arrest or conviction record, marital status, or religion, write immediately to your local WIC project. If you are not satisfied or if you do not get a response in approximately 30 days, write to DHSS, Affirmative Action/Civil Rights Compliance Office, P.O. Box 7850, Madison, WI 53707.

LOCAL WIC PROJECT: